United States Department of Labor
Employees' Compensation Appeals Board

R.F., Appellant	)	
and	)	**Docket No. 17-0113**
	)	**Issued: April 10, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Bellaire, TX, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On October 25, 2016 appellant filed a timely appeal from a September 14, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUE

The issue is whether appellant has established right upper extremity conditions causally related to the accepted factors of his federal employment.

FACTUAL HISTORY

On January 19, 2016 appellant, then a 66-year-old bulk mail clerk, filed an occupational disease claim (Form CA-2) alleging that he sustained right shoulder, arm, wrist, hand, thoracic, and elbow injuries from repetitive pushing and pulling of equipment, lifting tubs and trays, keying

[1] 5 U.S.C. § 8101 *et seq.*

on a computer, stamping, and reaching above his shoulders in the performance of his federal employment duties. He did not stop work. Appellant's supervisor noted that appellant was working modified duty six hours per day due to a previously accepted employment injury.[2] The record reflects that appellant accepted a modified work offer on June 29, 2015.

In a January 28, 2016 development letter, OWCP advised appellant that additional factual and medical evidence was necessary to establish his claim. Appellant was asked to submit additional factual information along with a comprehensive narrative medical report from his attending physician which addressed how his claimed employment activities caused, contributed to, or aggravated a diagnosed condition. He was afforded 30 days to submit the necessary evidence.

In January 11, 2015 and February 4, 2016 statements, appellant described the development of his medical conditions and the duties he had performed during his federal employment. He indicated that his full-time work hours were reduced in November 2014 to two hours a day because of his 2009 employment injury, but were eventually increased to six hours a day in June 2015.

OWCP received medical evidence in support of the claim. An April 14, 2015 cervical magnetic resonance imaging (MRI) scan report and December 8, 2015 electromyogram (EMG) report were submitted.

In a January 15, 2016 medical report, Dr. Ian J. Reynolds, a Board-certified orthopedic surgeon, discussed appellant's cervical and lumbar complaints.

Medical reports dated January 5 and 26, 2016 from Dr. Steven B. Inbody, a neurologist, were received. In his January 5, 2016 report, Dr. Inbody provided a clinical impression of cervical herniated nucleus pulposus with C4-7 radiculopathy (right) and thoracic outlet syndrome (right). He opined that appellant could continue to work in a modified position with reduced hours. Dr. Inbody noted that while appellant worked in a modified position with reduced hours, his symptoms of right cervical, trapezial and shoulder region pain and weakness progressed with referred pain down the interscapular region of the thoracic spine, pain, numbness and weakness of the right arm, forearm, and the extensor aspect of the forearm to the wrist with paresthesias affecting the fingers. He indicated that those symptoms directly correlated with appellant's continued bulk mail clerk work activities. Dr. Inbody explained that the required movements, which appellant only performed with his right upper extremity, gradually led to a repetitive stress injury of the right shoulder, arm and cervical spine, with neuropathic symptoms affecting his entire right upper extremity. He noted that, while appellant had an intact cervical fusion at C4-5, C5-6, and C7, the April 14, 2015 cervical MRI scan demonstrated significant spurring both above and below the fusion and that the April 14, 2015 MRI scan and EMG studies showed more significant pathology. Dr. Inbody indicated that this was consistent with a more proximal compression on the

[2] Under OWCP File No. xxxxxx352, appellant has an accepted occupational disease claim for injury on October 6, 2009 which caused neck sprain, brachial neuritis, or radiculitis; wrist sprain, left; sprain of shoulder and upper arm, left; displacement of lumbar intervertebral disc without myelopathy; displacement of cervical intervertebral disc without myelopathy; and enthesopathy of left elbow region. On March 10, 2016 the claim was updated to include cervical disc disorder with radiculopathy, mid-cervical region; other synovitis and tenosynovitis, right forearm; and radiculopathy, cervicothoracic region. Appellant stopped work as of January 24, 2016 and has received wage-loss compensation on the periodic rolls under this claim. This claim has not been combined with the current claim.

right potentially at the costoclavicular region which explained the extensor aspect of the symptoms down into the forearm, wrist, and hand, including all fingers. This would presumably be due to the myogenic neurovascular compression proximally as a result of a mechanical pain generator in the cervical spine which had continued to advance, as well as a result of the overuse of the originally asymptomatic right upper extremity.

In a January 26, 2016 report, Dr. Inbody requested that OWCP approve the diagnoses of cervical herniated nucleus pulposus with C4-7 radiculopathy (right) and thoracic outlet syndrome (right). He reiterated his findings contained in his January 5, 2016 report that appellant sustained significant new symptoms while at work as a bulk mail handler in his modified position. Dr. Inbody explained that appellant's symptoms directly correlated with his continued work-related activities. He noted that appellant performed repetitive pushing and pulling of heavy equipment, lifting tubs and trays of mail, keying on the computer, standing and reaching above his shoulders in his modified position which were within the physical restrictions he had ordered. Dr. Inbody indicated that appellant performed the required movements with only his right upper extremity, which gradually led to a repetitive stress injury of the right shoulder, arm, and cervical spine, with neuropathic symptoms affecting his entire right upper extremity. He stated the nature of the injury appeared to relate to the original cervical disc injury. Dr. Inbody explained that appellant's dependence at work on the more asymptomatic right upper extremity increased and as he continued with rigorous work activities, nearly identical symptoms to those on the left began to evolve both in the cervical and right trapezial region, down the right arm, forearm, and the extensor aspect of the forearm to the wrist causing tingling and weakness of the right hand and all fingers. He also noted that diagnostic testing supported a finding that appellant's symptoms had progressed in both the right and left upper extremities. Dr. Inbody opined that appellant's condition was consistent with a more proximal nerve root compression potentially at the cervical spine or alternatively within the costoclavicular region, which explained the extensor aspect of the symptoms down into the right forearm, wrist, and hand including all fingers. He opined that appellant's cervical disc herniation with radiculopathy C4-T1 and thoracic outlet syndrome were due to the repetitive pushing and pulling of heavy equipment, lifting tubs and trays of mail, keying on the computer, standing and reaching above his shoulder and was consequential of his initial injury of November 6, 2009. Dr. Inbody further opined that appellant was totally disabled from duty as of January 25, 2016, due to the new diagnoses of cervical disc herniation with radiculopathy C4-7 and thoracic outlet syndrome consequential to his initial injury of November 6, 2009.

By decision dated March 1, 2016, OWCP denied the claim as a medical diagnosis had not been established in connection with the accepted employment factors.

On March 29, 2016 OWCP received appellant's March 23, 2016 request for review of the written record by an OWCP hearing representative. Duplicative evidence was received along with appellant's February 4, 2015 statement, a January 28, 2016 cervical epidural steroid injection report, and diagnostic testing from May 11, 2012, June 27 and October 7, 2014, December 5 and 8, and April 14, 2015, February 23, April 14, May 4 and 5, 2016.

In an August 24, 2016 letter, the employing establishment disagreed with appellant's description of his modified job duties. It specified that it had provided and appellant had accepted a limited-duty job offer on June 29, 2015 for another claim. The job offer did not require lifting

over five pounds for more than two hours. It allowed sitting for five hours, walking and standing for no more than one hour, and pushing and pulling for no more than two hours. The employing establishment indicated that appellant performed those duties until he stopped work on January 25, 2016.

Additional progress and medical reports from Dr. Inbody were received. In an April 21, 2016 letter, Dr. Inbody indicated that appellant chose to proceed with the current claim to obtain approval for occupational repetitive stress injuries sustained on or about September 16, 2015, which caused total disability. He noted the history of appellant's November 5, 2009 traumatic injury, his medical course and the approved OWCP medical conditions. Dr. Inbody indicated that he continued to treat appellant for his original injuries and that appellant was gradually able to increase his limited hours at work with activity modification from two to four to finally six hours per day. He reported that appellant was able to meet his duties using primarily his far more functional right upper extremity to perform the rigorous physical duties of repetitive pushing and pulling of heavy equipment, lifting tubs and trays of mail, keying on the computer, standing and reaching above his shoulders, all within the physical restrictions he ordered up until September 16, 2015. As of September 16, 2015, appellant sustained the significant and sub-acute development of new symptoms which included right cervical paraspinal, trapezial and shoulder region pain and weakness which escalated while at work and was associated with pain, numbness and weakness of the right arm, forearm, and the extensor aspect of the forearm to the wrist with paresthesia affecting all fingers. He reiterated his opinion that appellant's work activities, which he performed primarily with only his right upper extremity, gradually led to a repetitive stress injury to the right shoulder, arm, and cervical spine, with neuropathic symptoms affecting his entire right upper extremity.

Dr. Inbody related that appellant's original left upper extremity symptoms also appeared to gradually worsen during the same time frame. Appellant remained at work and continued with his physically rigorous duties up until January 25, 2015, when he was determined to be totally disabled. Dr. Inbody noted that appellant's symptoms of right cervical and right trapezial region pain had been triggered and perpetuated by the unilateral use of his right arm for lifting, pushing and pulling and was secondary to his cervical disc herniation with radiculopathy and cervical postlaminectomy syndrome. He opined, "[o]bjective documentation in support of these requested diagnoses correlate with both the patient's clinical symptoms as well as the mechanism of injury as it relates to his occupational duties. The patient's symptoms of right cervical and right trapezial region pain have been triggered and perpetuated by the unilateral use of his right arm for lifting, pushing and pulling is secondary to his cervical disc herniation with radiculopathy at C4-T1 and cervical postlaminectomy syndrome." Dr. Inbody noted that the current EMG study demonstrated right upper extremity sensory and motor ulnar and median nerve injury consistent with a proximal nerve compression within the costoclavicular which explained the extensor aspect of appellant's symptoms. This would presumably be due to myogenic neurovascular compression of the lower brachial plexus proximally on the right, as a result of a mechanical pain generator in the cervical spine which has continued to degenerate as well as the overuse of the originally asymptomatic right upper extremity. Dr. Inbody concluded that appellant sustained further injury in the performance of his duties which resulted in cervical disc herniation with radiculopathy (C4-T1), cervical postlaminectomy syndrome; right brachial neuritis/radiculitis, and synovitis and tenosynovitis of the right forearm which were "directly or indirectly consequential" to his original injury of November 6, 2009 and rendered appellant totally disabled.

By decision dated September 14, 2016, an OWCP hearing representative modified the prior decision to find fact of injury established, but affirmed the denial of appellant's claim. The hearing representative found the medical evidence presented failed to provide a well-rationalized opinion relating appellant's diagnosed conditions to his federal duties based on a complete and accurate history of his reported work factors.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim, including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was filed within the applicable time limitation, that an injury was sustained while in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[3] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[4]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant. The medical evidence required to establish causal relationship, generally, is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[5]

ANALYSIS

The Board finds that appellant has not established that his right upper extremity conditions were causally related to the accepted factors of his federal employment.

Appellant had a prior 2009 employment injury under OWCP File No. xxxxxx352 which OWCP accepted for the conditions of neck sprain, brachial neuritis or radiculitis; wrist sprain, left; sprain of shoulder and upper arm, left; displacement of lumbar intervertebral disc without

[3] *Joe D. Cameron,* 41 ECAB 153 (1989).

[4] *See Irene St. John,* 50 ECAB 521 (1999); *Michael E. Smith,* 50 ECAB 313 (1999).

[5] *Victor J. Woodhams,* 41 ECAB 345 (1989).

myelopathy; displacement of cervical intervertebral disc without myelopathy; and enthesopathy of left elbow region. It subsequently accepted, on March 10, 2016, the additional conditions of cervical disc disorder with radiculopathy, mid-cervical region; other synovitis and tenosynovitis, right forearm; and radiculopathy, cervicothoracic region. The employing establishment indicated that appellant was working limited duty six hours per day as a result of the accepted 2009 injury. Appellant's restrictions were in effect from June 29, 2015 until he stopped work on January 25, 2016. He alleged that his right upper extremity conditions were due to repetitive pushing and pulling of equipment, lifting tubs and trays, keying on a computer, stamping, and reaching above his shoulders following his return to modified work after his 2009 injury.

OWCP denied the claim finding that appellant failed to present rationalized medical opinion evidence, based on a complete factual and medical background, which showed a causal relation with the accepted work factors.

In the present claim, appellant submitted several reports from Dr. Inbody. The record reveals that Dr. Inbody had treated appellant for his 2009 injury. Appellant returned to modified duty following Dr. Inbody's medical restrictions and using primarily only his right upper extremity. In his January 5 and 26, 2016 reports, Dr. Inbody diagnosed cervical herniated nucleus pulposus with C4-7 radiculopathy (right) and thoracic outlet syndrome (right) and related appellant's right-sided conditions to the original cervical disc injury. He noted that "this is consistent with a more proximal nerve root compression potentially at the cervical spine or alternatively within the costoclavicular region and thus explaining the extensor aspect of the symptoms down into the right forearm, wrist and hand including all fingers." These reports are found to be insufficient to establish appellant's claim. The Board has previously held that the need for rationalized medical opinion is especially important in cases wherein the employee had a preexisting condition.[6] The Board has explained that in light of a prior injury, rationalized medical evidence is particularly important to explain how the current conditions resulted from alleged employment factors, and not the prior injury.[7]

In his April 21, 2016 report, Dr. Inbody offered new occupational injury diagnoses of brachial neuritis/radiculitis, right and synovitis and tenosynovitis of forearm, right. However, he failed to provide a rationalized medical opinion which explained the nature of the relationship between the diagnosed conditions and the specific employment factors identified. Rather, Dr. Inbody continued to opinion that the new diagnoses were secondary or consequential to appellant's cervical disc herniation with radiculopathy (C4-T1) and cervical postlaminectomy syndrome. He indicated that appellant's symptoms of right cervical and right trapezial region pain, which had been triggered and perpetuated by the unilateral use of his right arm for lifting, pushing, and pulling, was secondary to his cervical disc herniation with radiculopathy at C4-T1 and cervical postlaminectomy syndrome. Dr. Inbody also concluded that appellant's conditions of cervical disc herniation with radiculopathy (C4-T1), cervical postlaminectomy syndrome, right brachial neuritis/radiculitis, and synovitis and tenosynovitis of the right forearm were "directly or indirectly consequential" to his original injury of November 6, 2009. The Board finds that Dr. Inbody's opinion on causal relation is of diminished probative value as he did not adequately explain or

[6] *See W.W.*, Docket No. 17-0422 (issued October 13, 2017).

[7] *See L.R.*, Docket No. 16-0736 (issued September 2, 2016).

describe physiologically how or why the modified working conditions appellant performed in his modified employment position caused the current conditions or aggravated appellant's preexisting conditions from his other claim.[8]

The remaining medical evidence is insufficient to support appellant's claim as it fails to contain a diagnosed condition or the established employment activities identified by appellant.[9] The diagnostic reports of record are also insufficient to establish appellant's claim as the physicians interpreted diagnostic imaging studies and provided no opinion on the cause of appellant's injury. Diagnostic studies are of limited probative value as they do not address whether the employment incident caused any of the diagnosed conditions.[10]

As there is no reasoned medial evidence explaining how appellant's employment duties caused or aggravated a medical condition involving his right cervical and right upper extremity, appellant has not met his burden of proof to establish a medical condition causally related to the accepted factors of his federal employment. As noted, causal relationship is a medical question that must be established by probative medical opinion from a physician.[11] The physician must accurately describe appellant's work duties and medically explain the pathophysiological process by which these duties would have caused or aggravated his condition.[12] The need for medical reasoning or rationale is particularly important given the fact that medical evidence of record indicates that appellant had preexisting conditions from another claim.[13]

On appeal, appellant argues that Dr. Inbody's reports support his claim. For the reasons discussed above, the medical reports are insufficient to meet appellant's burden of proof as they are not sufficiently rationalized.

Appellant may submit new evidence or argument as part of a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish right upper extremity conditions causally related to the accepted factors of his federal employment.

[8] *Solomon Polen*, 51 ECAB 341 (2000) (rationalized medical evidence must relate specific employment factors identified by the claimant to the claimant's condition, with stated reasons by a physician). *See also S.T.*, Docket No. 11-237 (issued September 9, 2011); *A.D.*, 58 ECAB 149 (2006).

[9] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[10] *See J.S.*, Docket No. 17-1039 (issued October 6, 2017).

[11] *Supra* note 9.

[12] *Solomon Polen*, *supra* note 8. *See also S.T.*, *supra* note 8.

[13] *See L.M.*, Docket No. 16-0143 (issued February 19, 2016).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 14, 2016 is affirmed.

Issued: April 10, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board